sick-listed. The level returned towards the preoperative level by the end of the study period (Figure 1). Hip OA patients tended to have more sick days before than after the THR (mean [SD] 98 [74] vs. 83 [82], p=0.08), while there was no such trend for TKR patients (96 [79] vs. 104 [79], p=0.3).
**Conclusions:** Return to work is faster after THR than TKR for OA. After joint replacement surgery. Close to 20-30% of patients remain sick-listed one year after surgery, the higher share being in patients after TKR, which is similar proportions seen preoperatively.

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### PREVALENCE OF GENERALISED JOINT HYPERMOBILITY, HYPERMOBILITY SYNDROME, MOTOR COMPETENCE AND PHYSICAL ACTIVITY LEVEL IN 8-YEAR OLD SCHOOL CHILDREN

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**Purpose:** Diverging results exist for children regarding the relation between Generalised Joint Hypermobility (GJH) and muskuloskeletal complaints, as well as relations between GJH and an insufficient motor development, and/or reduced physical activity level. With the different criteria used for diagnosing GJH, the prevalence of GJH varies considerable. The aim of this study was to survey the prevalence of GJH defined by a Beighton score either $\geq$ 4 (GJH4), $\geq$ 5 (GJH5) or $\geq$ 6 (GJH6) positive tests out of 9, and Benign Joint Hypermobility Syndrome (BJHS) in a Danish population of primary school children at 8-years age. A second aim was to compare children with and without GJH and BJHS regarding motor competence measured by physical performance test, self reported level and duration of daily physical activity, in addition to self reported incidence of musculoskeletal pain (arthralgia) and injuries (dislocation/subluxation).
**Methods:** The study was a cross-sectional study, where a population of 524 children in the second grade from 10 public schools in a mid size Danish municipality was invited to participate through letters to their parents. Clinical examinations including Beighton and Brighton tests for GJH and BJHS were performed. Further, physical tests to measure motor competence (agility, static balance, speed and hand reaction test) and a questionnaire including items on daily level and duration of physical activity, in addition to musculoskeletal pain and injuries were used. Of 524 children 416 (79.4%) responded, 411 (78.4%) children were clinically examined and tested for motor competence, and parents completed the questionnaire for 377 (71.9%) children.
**Results:** In total, 29% of the children had $\geq$GJH4, 19% had $\geq$GJH5, 10% had $\geq$GJH6 and 9% had BJHS, with no gender difference on the GJH and BJHS criteria. There was no difference in daily level and duration of physical activity, or in frequency of musculoskeletal pain and injuries between those with and without GJH. Children with $\geq$GJH5 as well as with $\geq$GJH6 performed better in the motor competence tests (static balance, speed and hand reaction test) than those $<$GJH5 and $<$GJH6.
**Conclusions:** Motor competence measured by physical performance tests and self reported daily level and duration of physical activity are not reduced in primary school children with GJH or BJHS at the age of 8. Future research designs must include longitudinal studies to detect a potential negative influence on the musculoskeletal system over time, due to GJH.

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### MANAGEMENT OF KNEE OSTEOARTHRITIS: COMPARISON OF GENERAL PRACTITIONERS AND RHEUMATOLOGISTS' PRACTICES

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**Purpose:** Little is known about the practices of primary care general practitioners (GPs) and rheumatologists (RHs) in terms of the management of knee osteoarthritis (OA).
Objectives: To determine potential differences between the profile of patients with knee OA managed by GPs and those managed by RHs, and to evaluate the nature of OA management by both physicians. To identify main factors associated with the prescription of low dose NSAIDs.
**Methods:** Cross-sectional survey of 808 GPs and 134 RHs in France. Each physician completed a medical questionnaire for the two most recent patients fulfilling the ACR criteria for knee OA. Information was collected on patients' characteristics, medical history, OA main symptoms and management. Statistical analysis was performed using SAS® software.
**Results:** The number of patients included by GPs and RHs were 1570 and 251 patients, respectively. For the total population (56.2% women), mean age was 67.4±9.7 years and mean BMI 29.0±4.8 kg/m$^2$. Of these patients, 89.7% reported disability in daily life, 47.2% had nocturnal pain and 30.1% had knee joint effusion. GP and RH patients suffered knee OA for 7.9±5.7 years and 6.8±5.5 years, respectively ($p<0.01$). Mean pain level in the knee (VAS 0-100 mm) was greater in GPs' than in RHs' patients: 49.8±16.3 mm vs. 46.2±17.1 mm, respectively ($p<0.01$). The proportion of GP patients with another joint affected by OA was greater than in RH patients: 71.2% vs. 63.7% ($p<0.0001$).
GPs and RHs prescribed drugs to 89.0% and 83.3% of their patients, respectively ($p<0.0001$). Drugs were acetaminophen (43.4%), low dose NSAIDs (13.4%), oral NSAIDs (33.7%), topical NSAID (29.0%), coxibs (8.5%), weak opioid analgesics (30.5%), strong opioid analgesics (1.9%) and SYSADOA (39.9%). GPs prescribed low dose NSAIDs ($p<0.0001$), oral NSAIDs ($p<0.05$) and topical NSAID ($p<0.0001$) more frequently, and SYSADOA significantly less frequently ($p<0.01$), than RHs. Intra-articular injection of steroid or hyaluronic acid were significantly more performed on RH Patient (31.5% and 46.2%) than on GP patients (7.6% and 2.5%) ($p<0.0001$). Moreover, GPs recommended rehabilitation ($p<0.01$) and weight loss for obese patients ($p<0.0001$) more frequently than RHs. Higher pain level was associated with both physicians prescribing coxibs and weak opioid analgesics more frequently ($p<0.001$). Overall, the main factors affecting the choice of treatment were safety of the drug and efficacy. In logistic regression analysis, prescription of low dose NSAIDs was significantly associated with GPs, retired patients, associated hip OA, no prescription of oral NSAIDs or coxibs, prescription of topical NSAIDs, no intra-articular injections of steroids and recommendation of rehabilitation.
**Conclusions:** This study identified variability in key aspects of management of knee OA as a function of medical speciality. Indeed, the clinical profiles of patients suffering from knee OA differed between GPs and RHs and as a consequence, the management varies over medical speciality. GP patients suffer for longer, have another joint affected by OA more frequently and have a higher level of pain. GPs prescribe more likely NSAIDs (oral, low-dose and topical) whereas RHs treat patients with SYSADOA more often and perform intra-articular injection of steroids and hyaluronic acid.